NEW PATIENT REGISTRATION FORM

Patient Name _____ Date of Birth _____

Birth Weight _____ Full Term Yes No
If not, how early? _____

1. Hospital where born _____

2. Stayed at hospital longer than mother (i.e.: NICU or Special Care Nursery) Yes No
   If yes, explain: _____

3. Any overnight hospital stays / admissions Yes No
   If yes, explain: _____

4. Any surgery/anesthesia/sedation Yes No
   If yes, explain: _____

5. Ever wheezed / used inhaler or nebulizer Yes No
   1. Ever diagnosed with asthma Yes No
   2. Ever prescribed an inhaler Yes No
   3. Ever prescribed a nebulizer Yes No

   If yes, explain: _____

6. Any mental health / behavior problems Yes No
   Any school / learning problems Yes No
   Any speech problems / late talker Yes No
   Any developmental delay Yes No
   If yes, explain: _____

7. Allergies to food / medication Yes No
   1. Reaction _____

   If yes, explain: _____

8. Any serious injuries / broken bones Yes No
   If yes, explain: _____

9. Any other health problems diagnosed? Yes No
   If yes, explain: _____